Amended Special Term and Condition 105.2a

State Fiscal Year 2009-10
Low Income Pool funding of
Funding Alternative Delivery Systems

Submitted May 31, 2010

1 Summary

1.1 *Introduction*

In November of 2009, the Agency for Health Care Administration (Agency, AHCA) requested of the Centers for Medicare & Medicaid Services (CMS) an amendment to the Special Terms and Conditions (STC) 105 of the Florida Medicaid Reform Waiver, Section 1115. This amendment allowed for the release of an additional $300 million in Low Income Pool (LIP) funds to the State for State Fiscal Year (SFY) 2010-11 that could have otherwise been retained by the federal government.

The amendment resulted in revisions to STC 105 which incorporate compliance with milestones related to the Financial Management Review and the approved Reimbursement and Funding Methodology document (RFMD) that modified the way cost limits must be calculated for SFY 2009-10, SFY 2010-11, and all future years; the requirement that entities begin reporting data ***quarterly***. The revisions also call for retroactive adjustment and reconciliation of all previous waiver Demonstration Year (DY) cost limit calculations using a regressive trend percentage. The amendment also required the Agency to report on LIP dollars currently allocated to participating providers that are within the operating budgets for State fiscal year 2009 – 2010 (SFY) to fund alternative delivery systems that provide ambulatory and preventive care services in non-inpatient settings by May 31, 2010. The following is the original and amended STC language as approved by CMS. This document provides the information required in 2(a) of the amended STC #105.

Original STC 105

At the beginning of demonstration year 5, $700 million will be available. An additional $300 million will be available at the time the demonstration is operating on a statewide basis for a total of $1 billion.

Amended STC 105

At the beginning of demonstration year 5, $700 million will be available. At the beginning of demonstration year 5, an additional $150 million will be available at the completion of milestones due on or before demonstration year 4 ending June 30, 2010. An additional $150 million will be available at the completion of milestones due on or before October 31, 2010.

1) The Florida Agency for Health Care Administration will:

   (a) Develop a draft reconciliation review tool and instructions, in consultation with CMS, to be used for the reconciliation of LIP expenditures by April 30, 2010. CMS will have 30 days to review the draft reconciliation tool, request additional information or approve the tool. The

'tool' will implement the following recommendations provided to the State in the Financial Management Review (FMR).

i. Written procedures to calculate the Medicaid Shortfall Amount will be provided to participating providers to ensure correct calculations.
ii. Written instructions and definitions and review procedures regarding allowable costs will be provided to participating providers to ensure that only allowable costs are being included.
iii. Written procedures will be provided to participating providers to ensure that the LIP cost limit forms are consistently completed.

(b) Provide CMS a schedule for the completion of provider reconciliations statewide for demonstration years 1, 2, 3, and 4 by June 30, 2010.

(c) Provide completed reconciliations, by demonstration year and by provider, for all providers for demonstration years 1 and 2 by October 31, 2010. Demonstration year 1 LIP expenditure reconciliations must use the DSH audit reports for verification of reconciliation results and method.

(d) Provide completed reconciliations for all providers for demonstration year 3 by March 31, 2011.

(e) Provide reconciliations for providers for demonstration year 4 by March 31, 2011.

For LIP hospitals that receive DSH funding, DSH audit results and a supplemental LIP report for primary care and ancillary provider distributions and STC #96, may be used as part of the LIP reconciliation. The results of the reconciliations must be reported to CMS with summary by provider and in aggregate for the LIP with sufficient details included or made available upon request for validation.

2) The Florida Agency for Health Care Administration will provide:

(a) A report of the LIP dollars currently allocated (by the State and/or health system) to participating providers that are within the operating budgets for State fiscal year 2009 – 2010 (SFY) to fund alternative delivery systems that provide ambulatory and preventive care services in non-inpatient settings by May 31, 2010. The report will provide a baseline assessment of current administrative capabilities and develop a reporting process to prospectively track the use of LIP funds allocated to hospital entities and subsequently used to fund uncompensated care in ambulatory and preventative care settings.

(b) An update with SFY 2010-11 projections for LIP dollars allocated (as described in 2 a) to participating providers by June 30, 2010. This update will include descriptions of increases to allocations and changes to current allocations.

Table 1 – CMS Deadlines to Implement Amended STC 105

Deadline	Milestone(s)	Description
April 30, 2010	1(a)	A review tool and instructions to be used for the reconciliation of the LIP expenditures to allowable provider costs. Specifically: ► Written procedures to calculate the Medicaid Shortfall Amount. ► Written instructions, definitions and review procedures regarding allowable costs that may be included. ► Written procedures that help ensure that LIP cost limit forms are consistently completed.
May 31, 2010	2(a)	► A report of the LIP dollars currently allocated to fund alternative delivery systems that provide ambulatory and preventative care services in non-inpatient settings.
June 30, 2010	1(b)	► Schedule for the completion of provider reconciliations statewide for Demonstration Years 1, 2, 3, and 4
June 30, 2010	2(b)	► SFY 10-11 projections for LIP dollars allocated to providers as in 2(a) describing increases and changes to current allocations.
October 31, 2010	1(c)	► Completed LIP reconciliations, by Demonstration Year, by provider, for all providers for Demonstration Years 1 and 2.[1]
March 31, 2011	1(d), 1(e)	► Completed LIP reconciliations by provider for providers for Demonstration Years 3 and 4.

1.2 *Purpose*

The purpose of this document is to meet Milestone 2(a) requirement of the terms of the amendment by providing a baseline report of the LIP dollars currently allocated (by the State and/or health system) to participating providers that are within the operating budgets for State fiscal year 2009 – 2010 (SFY) to fund alternative delivery systems that provide ambulatory and preventive care services in non-inpatient settings.

- This report will provide a baseline assessment of current administrative capabilities.
- Develop a reporting process to prospectively track the use of LIP funds allocated to hospital entities and subsequently used to fund uncompensated care in ambulatory and preventative care settings.

[1] According to CMS, "Demonstration Year 1 LIP expenditure reconciliations must use the DSH audit reports for verification of reconciliation results and method." This means that any hospital that received DSH and LIP funds must provide copies of their DSH audits with their reconciliation reports.

Goal and Design of Low Income Pool

On October 19, 2005, the Centers for Medicare and Medicaid Services (CMS) approved the 1115 Research and Demonstration Waiver Application for the State of Florida, relating to Medicaid reform. The Florida Legislature passed House Bill (HB) 3B on December 8, 2005, authorizing the implementation of the waiver effective July 1, 2006. In the Waiver Special Terms and Conditions (STC), #91, the Low Income Pool (LIP) is "established to ensure continued government support for the provision of health care services to Medicaid, underinsured and uninsured populations. The low-income pool consists of a capped annual allotment of $1 billion total computable for each year of the 5 year demonstration period." The parameters of LIP are defined in STCs #91 through #106.

STC #94 states that "LIP funds may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Act. These health care expenditures may be incurred by the State, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured, Medicaid shortfall (after all other Title XIX payments are made), may include premium payments for provider access systems (PAS) and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the State and CMS." A Provider Access System is further clarified below:

> Entities such as hospitals, clinics, or other provider types and entities designated by Florida Statute to improve health services access in rural communities, which incur uncompensated medical care costs in providing medical services to the uninsured and underinsured, and which receive a Low Income Pool (LIP) payment shall be known as Provider Access Systems. Provider Access Systems funded from the LIP shall provide services to Medicaid recipients, the uninsured, and the underinsured. Provider Access Systems shall be required to report data related to the number of individuals served and the types of services provided from the LIP funding.

In accordance with STC #93 and #100, the State submitted to CMS, on June 26, 2006, the Reimbursement and Funding Methodology document for LIP expenditures, which included the definition of expenditures eligible for federal matching funds under the LIP and entities eligible to receive reimbursement. The Reimbursement and Funding Methodology document is to be updated annually based on legislative appropriations. The LIP Provider Access System categories and qualifying criteria for participation are described in greater detail in the Reimbursement and Funding Methodology document. Funding for the state, non-federal share of the LIP program is provided through local government entities, such as counties and hospital taxing districts, and other state agencies (see Table 8).

As one of the conditions of the LIP, the hospital inpatient Upper Payment Limit (UPL) program was terminated. The UPL program was effective from SFY 2000-01 through SFY 2005-06 and included only hospitals. The LIP program allows for the continued support to many hospitals that

may have participated in the UPL, in addition to over 60 additional hospitals that were not UPL participants. LIP hospitals are included as the LIP Provider Access Systems. In addition to hospitals, other entities such as Federally Qualified Health Centers (FQHCs), County Health Departments (CHDs), and the St Johns River Rural Health Network (SJRRHN), are included as LIP Provider Access Systems.

The Provider Access Systems are required to annually submit expenditure documents to the Agency to confirm the LIP distributions are not in excess of the provider's shortfall costs for serving Medicaid, underinsured, and uninsured populations. In addition, the Provider Access Systems must document the numbers and types of services provided with LIP funding.

SFY 2009-10 LIP Funded Programs and Services

The General Appropriations Act (GAA) approved by the legislature for the SFY 2009-10 provides funding for the LIP. The funding is allocated to both hospital and non-hospital providers. The non-hospital providers by design are not providing inpatient services and are meeting the goals and design of the LIP program as above. However, there is a large portion of the funds that are being provided to the hospital providers that in efforts to more efficiently serve the communities and residents also utilize available funding to provide care to the underinsured and uninsured population. Without the funding for alternative programs such as primary care and emergency room diversion the uninsured and underinsured population would more often enter the health care system in more expensive settings such as the emergency room or as an inpatient stay due to delay in seeking care. Funds used by the hospitals are not specifically funded in the GAA and are not as easily identified as the non-hospital LIP participating providers. Due to the funding process, it is not clear that the hospitals that receive LIP payments in turn utilize the revenue into the facility as a funding source for non-inpatient services and meeting the goal and design of the LIP.

Many of the programs and services funding by the LIP revenue for hospitals are not new programs implemented at the time of LIP implementation but are programs that were able to be established through the UPL payment methodology that was operational in Florida prior to the implementation of the LIP. The continuation of the funding to hospitals under LIP provided a continued revenue source and allowed the hospitals to continue the services in alternative settings. In addition, there are providers that have expanded or established new programs, services or community agreements that were previously not able to be funded.

Identification of the programs, services and the associated funding for each provider is needed to more accurately reflect the distribution of LIP dollars between inpatient and non-inpatient services. In compliance with STC 105.2a, the following provides an explanation of the process the Agency used to collect information from the participating hospitals, the level of funding identified in the reporting that is allocated by the hospitals for non-inpatient services for the uninsured and underinsured.

Agency staff in communication with representatives from the hospital industry to identify the best way to identify and collect the information needed to complete this report. It was determined that in addition to holding an open conference call, a letter would be provided to the participating hospitals with a template explaining the requirement and the reporting instructions. Please see Attachment 1 for the standard letter and template that was sent out to all participating hospitals on May 13, 2010. The Agency set a deadline of May 24, 2010 for submissions to be considered for inclusion in the report. The requirements provided in the letter are as follows:

Reporting Requirements for the Providers:

The following information is required from each participating LIP provider for SFY 2009-10:
(Previous years may also be submitted.)

- The total amount of LIP dollars received and anticipated by year.
- A narrative description for each of the non-inpatient programs or services that are provided by the participating provider, and the start date of the programs or dates of changes or expansions that were possible due to receipt of LIP funding.
- The funding amount that is budgeted or anticipated for each program or service each year.

The LIP report submitted to the Agency for Health Care Administration (Agency) must contain key information that is mentioned in the amended STC #105. Each provider is required to provide the Agency with detailed dollar amounts and a narrative process for the amount of LIP funding that is used to fund non-inpatient services as well as specific primary care services. For example: ABC Hospital receives a total of $100,000 in LIP funding. Of these funds provided, $50,000 is used in primary care clinics, while the remaining funds promote outreach programs and/or other programs that benefit from these LIP funds.

The Agency received completed templates from 81.3 percent or135 of the 166 of the participating providers. The level of detail provided for the program description varied by hospital. Agency staff reviewed all submissions and incorporated the programs that clearly meet the goal of the program. All of the submissions meet the design and goal of the program, however with the information that was provided in the response, it is not clear at what level the program serves the uninsured or underinsured population as well as other populations within the communities. Clarification and more detail reporting instructions will be provided by the Agency to the hospitals to ensure the most accurate information for future reporting. The Agency will continue to work with representatives from the industry to establish detail reporting instructions and templates. Future reporting will be required of all participating hospitals on an annual basis to identify the programs and funding for non-inpatient services and programs.

Summary

The Agency received completed templates reflecting programs, services and funding provided by the LIP participating providers. The information was reviewed and grouped into categories for reporting purposes. This information is reflective of non-inpatient programs and services provided to serve the uninsured and underinsured. The following is a sample of services being offered:

- Primary Care Centers
- Outreach
- Dialysis
- ER diversion Programs
- Oncology Outpatient
- Diabetes care center
- Mammograms
- Rehabilitation Centers
- Wound Care Clinics

STC 105.2a Reporting Summary

Hospital funding programs outside of inpatient and emergency room	Total Amount
Primary Care	$209,291,941
Out reach	$ 26,798,944
Dialysis	$ 25,499,990
ER diversion programs	$ 23,648,567
Other	$138,404,880
Total	$423,644,322

Participating hospitals received $1,072,510,148 in LIP funding as appropriated for SFY 2009-10. Using the information provided to the Agency from the participating providers, a total of $423,644,322 or 40% of the GAA LIP hospital funding is currently being used to fund non-inpatient

services and programs. The Agency believes that this number is understated due to reporting factors. The Agency will work to improve the reporting template and instructions and as a result anticipates that this amount will increase for future reporting periods. In addition, as the economy continues to struggle, providers are always working to improve efficiencies and provide services in the least costly manner when possible such as primary and preventative care environments. The funding needs for the alternative non-inpatient programs and services is likely to exceed the level of funding available through the LIP payments for many providers that serve a high level of uninsured and underinsured within communities that depend on the hospital and hospital based programs for care. The funding reporting for each hospital included in this report does not exceed the LIP payments the hospital is authorized to receive for the fiscal year. For a detail listing of the information provided to the Agency and included in the table above please see Attachment II.

In addition to the program and services summarized in the table above, the Agency was given specific authority in the GAA for SFY 2009-10 to create a new category of LIP distributions to hospital providers. The category was primary care hospital LIP; the category's focus was to expand the access to primary care to the uninsured and Medicaid populations in Florida. The Agency provided an application to all interested LIP funded hospitals, after independent scoring four awards of $750,000 each was made to the top applicants. The Agency looks forward to evaluating the successful recipients programs to the number of additional individuals were served as well as the services they received.